PRINTED: 05/25/2011 FORM APPROVED

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				A. BUILDING B. WING	<u> </u>		С	
		NVN388AGC				04/18/2011		
NAME OF PR	ROVIDER OR SUPPLIER			RESS, CITY, STA	ATE, ZIP CODE			
SAINT JOSEPH CARE HOME-HIGHLAND  456 HIGH RENO, NV				LAND AVE ' 89512				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	(X5) COMPLETE DATE		
Y 000	Initial Comments			Y 000				
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility from 3/25/11 to 4/18/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.  The facility is licensed for 53 Residential Facility for Group beds for elderly and disabled person and/or persons with mental retardation, Category I residents.							
Y 050 SS=D	Complaint #NV00027 Tag Y050. 449.194(1) Administr Responsibilities-Ove		. See	Y 050				
	1. Provide oversight members of the staff to ensure that reside and protective super in compliance with the	a residential facility sha and direction for the of the facility as necess nts receive needed servision and that the facili he requirements of NAC i, inclusive, and chapter	sary vices ty is					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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AND PLAN OF CORRECTION IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
				A. BUILDING			С		
		NVN388AGC	B. WING			04/18/2011			
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	•			
			456 HIGHL	AND AVE					
SAINT JOS	SEPH CARE HOME-HIG	HLAND	RENO, NV	O, NV 89512					
(X4) ID	4) ID SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF		(X5)		
PREFIX TAG	(EACH DEFICIENC REGULATORY OR		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T		COMPLETE DATE			
170			,	170	DEFICIENCY)				
Y 050	Continued From page	e 1		Y 050					
	Continued From page 1								
		ot met as evidenced by							
		rom 3/25/11 to 4/18/11,	uie						
administrator failed to provide oversight and direction to the staff to ensure that the reside			ents						
	receive needed services they required (Resident #1 had head lice and did not get an appropriate treatment for it).								
Severity: 2 Scope: 3									
	333ps. 3								